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日本の歯科

(See Back Cover)

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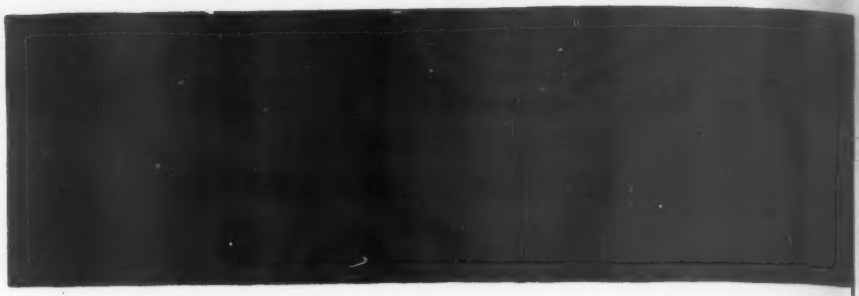

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A MAGAZINE FOR DENTISTS, DENTAL ASSISTANTS, AND DENTAL HYGIENISTS

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CONTENTS

TAKING FULL CROWN IMPRESSIONS
A simplified direct method through which "you can control the gingival fit." 1

CHERRY BLOSSOM DENTISTRY
Another interesting article in the International Dentistry series. An American Army officer evaluates the Japanese dental scene 3

DOCTOR KAMIYA
A fascinating biographical sketch of a prominent dentist of Japan 5

THE AIR FORCE DENTAL SERVICE
A photo-story of one of the great dental programs of modern times 8

ANGLES AND IMPRESSIONS
The quick-witted commentary of TIC's unique columnist.. 10

DENTAL WIVES
This exclusive TIC feature celebrates its third anniversary 11

HOW TO CARE FOR YOUR HANDS
Every dentist will read with profit this helpful article by a distinguished authority 12

IX FOR LIVING
Another installment in the three-part series on San Francisco's fabulous Doctor George A. Selleck 13

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A Simplified Direct Method:

TAKING FULL CROWN IMPRESSIONS

by Maurice J. Teitelbaum, D. D. S.

With more dentists performing a mouth rehabilitation service and doing dental orthopedics, dentists have become increasingly more aware of the necessity for full coverage in the construction of dental restorations. The full cast crown and veneer crown are not only favored for bridge abutments, but serve equally well for the tooth that is to receive a precision attachment or one that is badly broken down, in abnormal alignment, irregularly formed, badly discolored or is in any other way unsightly or a hindrance to normal occlusion and masticatory function.

Despite the channel grooves and accessory anchorage pits of the three-quarter crown, there is no doubt that the full crown affords better retention. Just as the trend swung away from the gold inlay as an abutment to the three-quarter crown because its added occlusal coverage countered vertical dislodging forces, so the trend is now in the direction of the full crown because of its greater retentive structure. The full cast crown is certainly no stranger to dentistry and even the full veneer crown was used as a restorative medium a half century ago. Today, the pendulum is merely swinging back in its favor.

Advanced laboratory techniques have given added impetus to full crown construction, for the acrylic veneer crown now processed is superior in appearance to the gold-rimmed carmichael. And in fixed bridgework, it is evident that a pontic matched to a veneer is usually more esthetic than a pontic matched to the color of a natural tooth. An added factor in favor of full coverage is the minimal marginal area it presents, thereby lessening the chances for the development of caries and the undermining of the restoration. Finally, those operators who are full coverage enthusiasts claim that the preparation and impression techniques for the full crown are simpler than those used in the construction of the three-quarter crown. Perhaps the greatest objection to the full crown has come from those who consider the preparation of a veneer of radical procedure. Yet, hundreds of properly finished preparations of veneer crowns are seen

wherein portions of cement, silicate, gold foil and amalgam are still retained. Cutting for full coverage is actually less radical than that produced by the deep intercoronal penetrating grooves and pits necessary in the three-quarter crown preparation.

The preparation of the full crown or labial shoulder veneer does not vary to any great extent among operators. However, in taking the impression we find a variance of methods, not only in the materials used but even in the approach.

One of the newest techniques used by many of the leading dentists is a direct method which is simple enough for the average dentist to master, and, with a little practice, can be done in twenty minutes. It is a technique which produces an excellent fitting crown, accurately extended to the limits of the preparation and beautifully formed—if the laboratory can follow through on its part of the procedure.

How to Do It

Here is a resume of this full crown impression technique, step-by-step:

1. Select a slightly oversized copper band and festoon it. In fitting it over the tooth, you may have to alter the shape of the band from a round cylinder to one that is larger buccolingually. If so, merely squeeze the band to shape but be sure that the diameter of the band is not smaller at the part that is seated over the tooth, or later on you will not be able to push the wax out of the band. It is not necessary to anneal the band. Be sure when trying it in place that there will be an even thickness of wax around the gingival. Now reduce the size of the band with a scissors or disk so that it is shorter and easier to work with, but leave it long enough for the wax to cover the extent of the preparation. Don't hurry in preparing the band, for this is an important part of the technique. A poorly prepared and ill-fitting band will make it difficult for you to get a good impression and will only cause you to waste time and start over again. Now lubricate the inside of the band with a lubricant like Kerr's Microfilm and you are ready to insert the wax.

2. Kerr's medium blue wax works well for this writer, but use the type of inlay wax that you are accustomed to handle. It makes little difference as long as it is an accurate material and you can work with it easily. Heat the wax until it is properly softened and then fill the band. Smooth the wax with a hot instrument and then place the band over the tooth and with your finger over the top of the band seat it well into place with straight vertical force.

3. Chill the band and remove the excess wax about the gingival. Then, gripping the band with a small piece of gauze, remove it gently and vertically. (On occasion the band may come off without the wax. In this case just remove the wax with the gauze between your fingers and, if the impression is satisfactory, the next step can be eliminated.)

4. Inspect the wax impression. Is it satisfactory? Does it cover the extent of your impression? If it is a veneer preparation, is the shoulder sharp and clean? If so, remove the wax from the band by gently pushing the wax out with the back of a hand instrument. If the band is properly prepared and lubricated, the wax will easily slide out of the band. If there is any wax running over the margin and clinging to the outside surface of the band, clear it off before attempting to shove the wax through.

5. Now inspect the pattern. You should have a fine reproduction of the inner aspect of your crown. To inspect the margin more carefully it is advisable to use a high powered hand magnifying glass. Now you trim your gingival margin to the exact extent of the finished margins that you desire in the finished crown. Use a sharp scalpel to cut off the excess wax and trim the margin if it is too thick. Check the labial shoulder if it is a veneer and see that the wax extends just a bit below the edge of the shoulder. You do not want a butted joint.

6. Next, seat the pattern back on the tooth carefully and check the gingival margin again to make sure that it is not short. With a warm instrument you may go over the gingival slightly to correct any discrepancy. Then take a quarter-inch smooth amalgam finishing strip and after making a horizontal cut in the center of about a half-inch, pull one of the ends through the slit to form a loop. Notice that the circumference of the loop is smaller on one side than the other. Place the loop over the pattern so that the smaller part grips the gingival portion of the tooth. Now, with the forefinger of one hand holding down the pattern, with two other fingers grasp the ends of the strip and tug at it gently, thereby tightening the loop. This will readapt the wax pattern more snugly about the tooth. Take the strip off and remove the pattern gently.

7. Take a wax bite and sectional impression in DP or similar material and your work is completed.

From here on your laboratory man carries the ball. First, he pours a cristobalite die from your pattern which he treats with an acrylic spray (Krylon) to protect the margin. On the stone model obtained from your sectional impression, he waxes up a veneer crown which is anatomically correct. This wax-up is then seated on the cristobalite die. The gingival margin is waxed up and the entire thing is invested and cast. The result is a beautiful fitting and carved crown.

The distinct advantage of this technique over any completely indirect method, no matter how accurate the material, is that in this procedure you can control the gingival fit. There is no guess work on your part or on the part of the laboratory man as to where the preparation ends. To some extent a restoration is as good as the margins, and with this direct method you can be sure that your margins will be good!

International Dentistry:

日本の歯科 Cherry Blossom Dentistry

by James O. Goldman, D. D. S.

The year was 1911; the place, Osaka — Japan's second largest city. A far-sighted group of dentists applied to the governor of Osaka Prefecture for permission to establish the Osaka Dental School.

The first classes were held in February 1912. The school, the third of its kind in Japan, was set up on the American system. It could hardly have been set up otherwise, because the three deans of the school graduated from American institutions. The present dean, Doctor Junichiro Iizuka, graduated from the Colorado College of Dental Surgery, University of Denver, in 1918.

The history of the Osaka Dental College closely parallels the history of the other dental institutions of Japan. All of them have been confronted with the same major problems, and the story of one is the story of all.

After it had been moved about the city of Osaka several times, the present-day Osaka Dental College was completed in Hirakata City, a small village located between Osaka and Kyoto. That was in 1929. It is situated in a locale that is unusual, and the atmosphere is conducive to study and attainment.

The Dental Hospital of the Osaka Dental College at Osaka.

The campus is on a hill overlooking the plains of Settsu and Kawachi, which the Yodo River traverses. The school seems to reign majestically on its elevation, surpassed only by a high range of mountains that seem to ring it in a distant perimeter.

This plant proved quite adequate until the middle thirties. Then it was decided that the clinical portion should be relocated in the city of Osaka. The dental hospital was erected. It was located in a spot that was easily accessible to the residents of the city, so it provided a wealth of clinical patients for the students.

At the outbreak of World War II, the Osaka Dental College was operating in a normal manner, as were the other dental colleges in Japan. The Japanese educators were on the verge of elevating dentistry from a "mechanical and aesthetic art" into a medical service having vital relations with the health of the body as a whole. They were shifting the emphasis from restoration to prevention—a movement that American educators had already started.

They were just beginning to assimilate the fruits of Western research and were on the verge of achieving remarkable results when World War II broke out. This drove Japanese dentistry into a state of frenzied confusion.

Postwar Efforts

At the end of the hostilities in 1945, new efforts were made to rehabilitate dental education in Japan. Despite the many problems created by postwar conditions, there have been some remarkable reformations in this field. One of the most important features of the reform was the elevation of the standard of the dental college into the status of a university.

This was done through the close cooperation of

The Osaka Dental College at Hirakata City.

educators and dental practitioners of Japan. Following the general renovation of Japan's educational system, the dental colleges were also revised to become a part of the eighteen-year course of university standard, instead of the fifteen-year course of the college standard of the past — that is, the 6-5-4 system was replaced by the 6-3-3-2-4 plan, as outlined by the Council on Dental Education. It was also decided that a pre-dental course should be opened.

The Osaka Dental College was quick to fall into line on the reform measures. The college was enlarged and the teaching staff was organized to undergo inspection by the authorized Committee of the Ministry of Education. In the short period of two years, it was recognized as a dental college of the University Standard.

Realizing the importance of dental care for 80,000,000 people and the inadequacy of 30,000 dentists to perform the desired services, the reformers went even farther. Efforts were made to enlighten the public on the care of their teeth through educational programs. The National Council on Dental Education was formed, also the Japan Association of Dental Schools, and the Council of Dental Education Standards. The Board of Dental Inspection was created to inspect the workings of the dental schools in the country, and the National Dental Examination was instituted and put into practice.

A Visit to Osaka

On a recent visit to the Osaka Dental College, the writer was able to see the retarding effects of war on dental education. We visited the dental infirmary first. It is a modern, three-storied building, whose last story was added in 1950. Once inside one could see that the modernity of the outside of the building was not indicative of the inside. Nothing new in equipment had been added in many years, but the ingenious Japanese were taking full advantage of what they had.

The writer's visit was made while the National Dental Examination was being held. It lasts eight days, three of which are devoted to written work and five of which cover the practical aspect of dentistry. The examination was being taken by 290 graduates, several of whom were women. The work done on the practical examination was comparable to the work of American dentists just graduating from dental school. It was certainly impressive to see the quality of the work done by the group as a whole in view of the scant equipment that they possessed.

The academic school is housed in what once had been a beautiful building, but was then shabby and dirty and even had broken windows. The building had not carried its twenty-odd years well.

Inside, conditions were the same. There had been no recent improvements. The laboratories were dirty and cluttered—the equipment long since outmoded. Yet in the midst of all this uninterrupted deterioration uninterrupted progress was being made. Doctor Yoshio Umemoto was busily engaged in a research problem when the writer entered the bacteriology laboratory. He was a former captain in the Japanese army and had returned to the school to become the head of the bacteriology department. He was a most affable person and eagerly explained the nature of his work and demonstrated equipment that he had designed and exhibited microphotography of this work.

He accompanied the writer to the oral pathology department, where, in the same sort of atmosphere, we found Doctor Toranosuke Ono, head of that department. He is a very active and distinguished man, despite the fact that he is seventy years old. And he is famous in Japanese dental circles. In 1930, when Doctor A. D. Black, then Dean of the Dental School Northwestern University, toured Japan, he lectured at the Osaka Dental College. It is said that during his visit he asked Doctor Ono to return to Northwestern with him. The latter refused because he felt that he could be of more service if he stayed and taught in Japan.

Doctor Ono proudly displayed to the writer his collection of dentures. Some of them were over 300 years old and had been used long before George Washington was fitted with his famous set. They were carved of wood and were truly works of art. In this collection there was a clear picture of the evolution of dentistry, but all of them had been made of the best material available at the time they were made.

One of Doctor Ono's most treasured possessions was a book on dentistry published in 1774 in Paris. He confirmed the authenticity of the publishing date by holding one of its pages to the light so I could see the 1774 watermark on it. It is the only copy of the book in Japan. The author was Pierre Fauchard, the father of modern dentistry.

The laboratories were more deplorable than the main academic building. Working with equipment that had probably been purchased decades ago, the students nevertheless were busy turning out models that were masterfully done.

To the rear of the main building was evidence of the reformation that had radically changed dental education in Japan. A semi-circular group of relatively new buildings nestled there, housing the newly created pre-dental school.

(Continued on page sixteen)

Doctor Kamiya

Diver, Soldier, Bacteriologist, Linguist, Coach—and Dentist

by James O. Goldman, D. D. S.

In 1928 Shigeyoshi Kamiya, like many other Japanese boys his age, became interested in diving. He devoted many tiring hours to practicing on the highboard and springboard. He joined a small athletic club at Koshien. In two years he achieved such a degree of proficiency in his specialties that he was chosen to represent his club in the regional games. He placed first in both the high dive and the springboard and was declared the champion of West Japan in both.

In 1931 he represented the Koshien club in the All Japan Championship games, a great honor because the winners in those games were to represent Japan in the Olympics to be held in Los Angeles in 1932. It was the dream of every Japanese diver to represent his country in the Olympics. Kamiya set up a severe training program for himself, spending countless hours seeking more grace and form for his near perfect dives. But fate interfered. He suffered a back injury.

Diving Career Ended

He lay in the hospital for weeks, unable to move. This was followed by more weeks in bed at home. It was a year before he recovered sufficiently to return to school, a sad and dejected lad. He had missed an almost certain berth on the Olympic team and his ambitions as a diver had been shattered.

In 1936 Kamiya graduated from middle school, the equivalent of the American high schools, and chose dentistry as his profession. At that time no college preparatory work was necessary. The prerequisites of dental school were six years of primary school and five of middle school. He enrolled in the Osaka Dental College and began the study of dentistry with characteristic zest.

Soldier

When he had completed one and one-half years of the four-year course, fate again intervened with his plans. He was drafted into the Japanese Army for the war being fought in Manchuria. His major assignment in the war was—washing horses! The Japanese Army was prone to disregard a man's qualifications and aptitudes in placing their personnel. After eight months, the Army declared Kamiya surplus, and he was discharged and permitted to re-enter dental school.

When he returned to dental college, he became intensely interested in bacteriology and learned to read German in order to study the works of some of the leading bacteriologists. As a result of his learning in this field, he became an assistant in the bacteriology department while he was still working on his dental degree. The dean of the college realized young Kamiya's potentialities and suggested that he learn to write and speak English so that he could come to the United States to study. With this encouragement, he acquired a working knowledge of English.

In March 1941 he received his degree from the

Doctor Kamiya and a Japanese medical technician who worked on bacteriological problems in Manchuria.

Osaka Dental College and was ready to begin his new career. He went to Tokyo to obtain a job and got one in the Institute of Infectious Diseases, not as a dentist, but as a bacteriologist. Four months later the Japanese Army, preparing for World War II, sent him a notification that he was being drafted for the second time.

After his induction, he was sent to Manchuria with the 12th Heavy Field Artillery Regiment, which was assigned to the Japanese 5th Army. He had volunteered for duty as an artilleryman because their tour of duty was supposed to be shorter than that of a dentist. He was given the rank of private first class and the duties of a wireless operator. Since weapons were still being horse-drawn, he had to spend part of his time washing and caring for the horses.

Doctor Kamiya found his duties dull, so he sought other activities on which to expend his energy. The only dentists in the Japanese Army were located in the hospitals, so he asked the regimental commander for permission to do dentistry for his fellow soldiers in their company area. The commander agreed, provided he would furnish his own instruments and supplies. He immediately wrote his father and had him send him his necessary instruments and materials. With a wooden chair,

constructed for his use by a carpenter, he began taking care of the dental needs of the troops.

As a reward for his extra efforts, the commander gave him the privilege of burning his lights at night as long as he pleased, and his father sent him his bacteriology books. A friend in Osaka suggested that Doctor Kamiya contact a Mr. N. A. Baikoff in Harbin, which was nearby.

Baikoff was a deposed Russian colonel who had sought refuge in Manchuria after the Bolshevik Revolution in 1920. He was on the Committee of the Foundation of the Harbin Museum and an honorary member of Manchurian Research. At that time he was engaged in writing books. The friend of Doctor Kamiya's who had suggested that he contact Baikoff had read some of his works and thought that Doctor Kamiya could get help from him in obtaining new books.

Doctor Kamiya established a friendship with Baikoff that lasted throughout his stay in Manchuria. He obtained the books that he needed and learned the Russian language as well. The Baikoffs had a daughter, and a romance soon began between her and Doctor Kamiya.

Bacteriologist

The field of bacteriology was "wide open" in Manchuria. In 1939, in the Songo District, there had been an outbreak of a new disease. It reached epidemic proportions and was called Songo fever. In 1941 and 1942 it broke out again and affected the troops stationed there more than it did the natives, probably because the natives had built up a tolerance to the disease.

Private Kamiya, Miss Baikoff, and N. A. Baikoff, at Harbin, Manchuria.

With meager equipment and a few books, Doctor Kamiya began some research on this strange malady. After the harvest was over in that area, great hordes of mice descended on all the buildings, seeking food. He trapped many of these and studied them. They were infested with fleas, lice, and mites. After weeks of research, he concluded that human beings contracted the disease because of the bite of the mites that the mice played host to. He sent the reports of his findings to the Corps for the Study of Epidemic Diseases, an organization of the Japanese Army, but the Corps was indifferent to them.

However, a civilian employee for the Corps, formerly a worker in the Institute of Infectious Diseases in Tokyo, saw the reports and realized the importance of the work that Doctor Kamiya was doing and presented the reports to the Corps commander. Doctor Kamiya soon received a microscope, rat cages, and other necessary equipment to continue his research. In 1942 the Japanese officially called the disease Epidemic Hemorrhagenic Fever. The United States Army had known about the disease since 1946 but did not face the problem of dealing with it until 1951.

Near the end of his scheduled tour of duty in the Japanese Army, Doctor Kamiya had great plans for the future. He would remain in Manchuria as a civilian employee and continue his research, which had reached extensive proportions. But his tour of military duty was extended because he was so young. All of his companions were released and sent to Japan, except eleven. He was sent with them to the Philippines to bolster the forces on Luzon. That was in 1944.

The regiment he was in was equipped with twenty-four year old cannons. They were inferior to the American guns and had half the range. By day they would hide the guns out of range of the American artillery and out of sight of the observation planes that infested the sky over Luzon. At night they would advance the guns within firing distance of the American positions and lay down their barrages.

War's End

By the time of the surrender in September, there were only fifty members of his regiment alive. Doctor Kamiya was assigned to the staff in charge of the surrender of hospital troops, because of his ability to speak English. The hospital patients were the last to come down and surrender because they

were farthest away in the mountains. Since Doctor Kamiya had surrendered along with them, he had been mistaken by the Americans for a patient and was so dealt with during his stay in the prisoner of war camp to which he was assigned. At that time he was a sergeant and his prison duties were that of platoon leader.

One day the commander of his camp discovered him extracting teeth for some fellow prisoners with some old forceps he had found. That night the commander mentioned this fact to an American dentist in charge of the dental clinic of one of the camps. The dentist, Doctor Harry Cantor of Brooklyn, N. Y., asked that Doctor Kamiya be sent to his clinic the following day. He had tried to use several Japanese dentists but had been unable to find one who could do the work.

Doctor Cantor put Doctor Kamiya to work extracting teeth for fellow prisoners. He did such a good job that he gained the confidence of all the Americans around him. He was very proud when Doctor Cantor left him in complete charge of the clinic while he made trips to Manila or otherwise absented himself.

The hospital patients were the first to be sent home to Japan, and Doctor Kamiya had been classified as a hospital patient. On December 5, 1945, he worked his last day and was placed on a ship to return home. He looked forward eagerly to a long-awaited happy reunion with his family. But when he arrived home, he found that his mother had died a month before and his father was disabled and had to be cared for, along with his three sisters and a brother.

Dentist

For seven months he worked for another dentist in private practice, then, on the suggestion of the dean of the Osaka Dental School, he obtained a job with the United States Army Hospital in Kobe. His purpose in accepting the job was two-fold: He could provide for his dependent family and at the same time better his dental technique by observing and working with American dentists.

He has worked at Kobe for several years now and during this period he has transmitted to the dean of the Osaka Dental School all the information he has been able to obtain on American dental techniques and materials. The dean uses this information in the school.

Coach

Despite the heavy work load he has carried, he has found time to devote to his first interest—diving. Now, in his early forties, he is instructing and developing promising young divers for the New Japan. The old Koshien athletic club is now known as the Kobe-Osaka Athletic Club and has, not eight, but sixty members. Last year one of his girl-divers won first place in the high dive and the springboard, and one of his boy-divers placed first in the high dive and second in the springboard.

He is called upon constantly to serve as an official in the All Japanese Meets. In 1950 he was one of the officials in the races between Marshall of the United States, Honno from Hawaii, and Furuhashi of Japan. He thinks that Honno is one of the greatest swimmers that he has ever seen. Doctor Kamiya was awarded a medal for his work as an official in 1950.

Near his home there is a hospital for the mentally ill. It is owned by a friend who attended medical school while Doctor Kamiya was attending dental school. The owner, four other physicians, and two pharmacists comprise the staff. At night, when Doctor Kamiya has finished his day's work at the Army hospital, he attends the dental needs of the patients in this hospital. He receives little compensation for this because most of the patients are charity cases.

His greatest love is for bacteriology, and he wants to get back into it as soon as family conditions permit.

What will become of this man who has been so much a pawn of fate? Perhaps he will find the key that will unlock the mysteries of the Epidemic Hemorrhagenic Fever. Time will tell.

Doctor Kamiya in the U.S. Army Hospital, Kobe, Japan, working on a patient while Ichiro Yokoi, Japanese dental student training at the hospital watches. (U. S. Army Photo)

THE AIR FOR NT

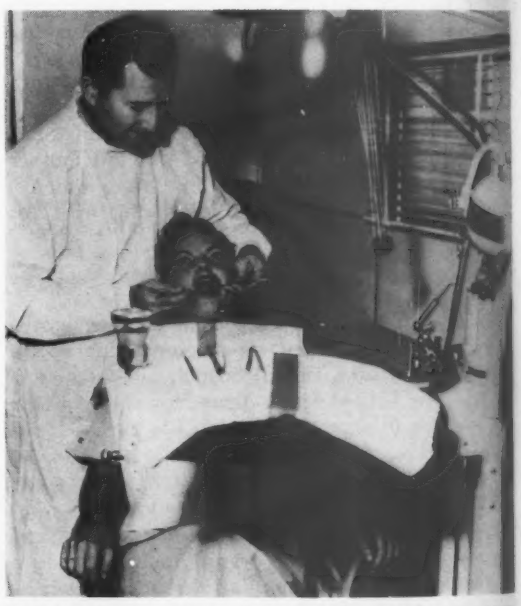
Text and ph ticated

To keep the United States Air Force in the air, it is a must that all the crews be in A-1 physical condition. The Air Force dental service contributes greatly to this end. Dental care is available to all Air Force personnel, even though they may be stationed at remote and isolated outposts.

A clinical camera being used at the dental office of the Air Force in Japan. Doctor Julius N. Obin photographs the mouths of all patients before and after treatment, to maintain a visual record of their dental progress.

Brothers working at the U. S. Far East Air Material Command's Dental Clinic in Japan. They are 1st Lt. Arthur C. Ophoff and Capt. Earl F. Ophoff of Grand Rapids, Mich. Since entering the Air Force together, they have been continually assigned together. The Ophoffs practiced dentistry in partnership in their home town after graduation from the University of Michigan School of Dentistry.

Maj. General Harry G. Armstrong, Surgeon General, USAF, pinning a lieutenant bar on 1st Lt. Raya Rachlin. She is the first women dentist to be sworn in to the U.S. Air Force. Witnessing the ceremony is Col. Walter H. Bird.



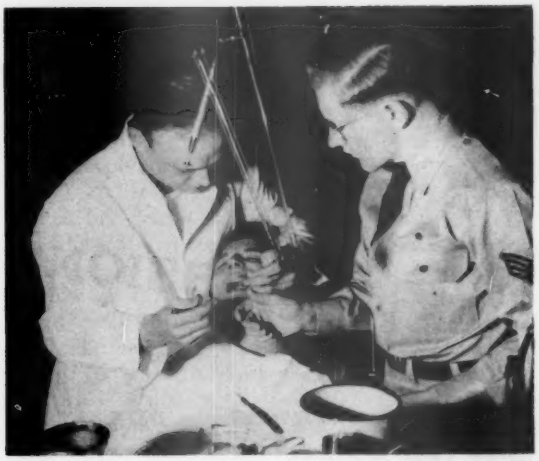
Lt. Col. Sydney G. Gordon, USAF, provides dental treatment to WAC Sergeant Virginia James in one of the two dental chairs in the new mobile dental unit developed by the Air Defense Command. Lt. Col. Gordon is credited with perfecting the equipment and techniques used in the mobile units, which are designed to make the best dental care available to Air Force personnel stationed at remote and isolated outposts. The Air Defense Command has constructed six such units, each manned by a crew consisting of two dental surgeons, one dental assistant, one laboratory technician, a driver and maintenance man. Each unit is equipped with the latest developments in dentistry and can provide any treatment necessary to a patient, including complete dentures.

NTAL SERVICE

icated News

WAF Corporal Ruth G. Blackburn assisting in the Dental Clinic at the Travis Air Force Base, California Hospital. Corporal Blackburn has been with the WAFs a number of years and is learning to be a dental assistant.

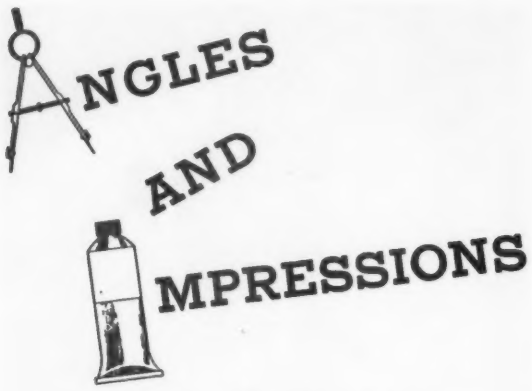
Dental care at the 136th Fighter Bomber Wing in Japan. Capt. Robert Hess, Jr., is giving a dental checkup to a member of the Bomber Wing. Dentists report that more than three-fourths of the Wing personnel are in Class I dental condition.



A WAC corporal receiving treatment at the Randolph Air Force Base in Texas.

A dental laboratory technician with the 3204th Medical Group at Elgin Air Force Base in Florida.

1st Lt. Louis F. Parker examining a patient at an advanced Air Force Base in the Far East.



by Maurice J. Teitelbaum, D.D.S.

Dental Thisa and Data

The most recent count by the ADA Bureau of Economic Research and Statistics shows that the United States has 93,726 dentists or one dentist for every 1,677 persons. This is an increase of almost 3,000 over last year. Actually, of the total number of dental practitioners, 85,970 are civilian dentists and 7,756 are in government service, which includes the Armed Forces, the Veterans Administration, and the U. S. Public Health Service. The remainder are in U. S. territories and possessions . . . Once more the areas with most dentists per capita are concentrated on the east and west coast. Individual State leaders are New York, Minnesota, Connecticut, and Massachusetts. States with the least number of dentists per person are South Carolina and Mississippi . . . The annual meeting of the American Institute of Dental Medicine will take place at the Desert Inn, Palm Springs, California, October 31—November 4. Some of the topics covered at the round table forum will be "Soil and Nutrition," "Recent work in Carbohydrate and Fat Metabolism," and "Diseases of the Tongue and Oral Lesions." . . . New York University has begun the establishment of an Institute of Dental Research as part of the University's College of Dentistry. This was made possible by a grant of a half million dollars from the Guggenheim Foundation.

Inci-dentals

A retired New York dentist, Doctor C. W. Fuller, is the inventor of the "Gilhoolie"—a neat gadget that is used to open bottle tops and caps of jars, remove corks, and stoppers, etc. . . . And incidentally, the originator of the electric chair was also a dentist, Doctor A. P. Southwick, of Buffalo, New York. It's truly amazing how dentists can branch off into such diversified fields—inspired by such things as a crown remover and a burnout oven!

Gagging

Herein is a dentist's version of the chronological history of the world:

2350 B. C.—Yao, emperor of China, was the first man to clean and drain canals. No antibiotics were used, because sterilization methods were not known.

550 B. C.—Dentistry came of age during this period when the value of teeth and the masticatory apparatus became known. This era in history was known as the Chou Dynasty.

30 B. C.—The recognition of the science of orthodontics. Cleopatra angered an asp and died as a result of a cross bite.

1112—The first failure in dental restorative work was noted as Henry V had to be crowned for the second time.

1200—The need for periodontal treatment became apparent as Ghengis Khan continued his conquests because of the tartar in him.

1527—Instrumentation became standardization and crooked explorers made their appearance. Cortéz was in Mexico and Pizarro was in Peru.

1620—Dental problems became more complex as Harvey described the circulation of the blood. Before then, blood never left the heart and there were no exposures.

1725—Prosthetic dentistry makes great strides. From Sir Isaac Newton's laws of gravitation dentists learned why upper dentures came down. Unfortunately, Sir Isaac died before he could reveal why lower dentures came up.

1729—Carolina is divided into North and South, which later necessitated an extra set of dental State board examinations.

1733—The first recorded step toward the prevention of dental decay on the part of any government. The English Parliament passed the Molasses Act, which put a heavy tax on sugar.

1775—Paul Revere, early American dentist, rode about and inspired many minute men to start drilling.

1804—The need for dental education and training was recognized; for, when a Burr killed Alexander Hamilton, dentists came to understand that dental instruments in untrained hands might serve a dual purpose.

1820—Maine was admitted to the Union. This was important to everyone in the country including dentists. For the Union didn't know which way to go until Maine became a State.

1859—Charles Darwin published his *Origin of the Species* and made a monkey out of everyone.

1930—A great depression appeared which all the gold and silver could not fill.

1939—Lateral excursions to the left and right by a German dictator caused great destruction and trauma.

1954—Slight recession is observed in America, probably caused by trauma begun in 1939.

Dental Wives:

Anniversary

by Kay Lipke

Three years ago this month this writer placed her first article with TIC. It was a short, semi-humorous bit entitled "I Love My Dentist," but in the letter of acceptance from TIC's editor came the suggestion for a series of articles on dental wives and the different ways in which they help their husbands in the home, the office, and the community.

Suddenly a gate swung wide open to an entirely new experience. Until that moment, the writer had not given any particular thought to exactly what it meant to be the wife of a dentist. For that matter, she had not put down in black and white any rules for being a wife, dental or otherwise.

However, no one can write more than thirty articles on dental wives and marriage without gaining immeasurably in a better understanding, not only of other people, their successes, and their problems, but also of one's own experience. It has been a most worth-while education.

Armed with pencil, notebook, and a mind crammed with questions, it has been her fun and her privilege to talk with many dentists and their wives. She has had the opportunity to walk past the polite little small talk which usually qualifies as social conversation, and has had the privilege of looking deep inside the minds and the lives of a good many dental wives. She has been both interested and inspired.

The fun has come in meeting new, interesting, and fine people, and especially in coming to know the wives of the men with whom her husband has had pleasant professional contact for years. Almost to a person she has felt a warm bond of fellowship with them.

Some of the wives assist their husbands in the office, some never go near the office, and some have separate careers of their own, but nearly all of them are united in the connection that dentistry is a fine profession, although a difficult one. They are proud of their husbands, but earnestly wish they would not work quite so hard. Usually they have evolved for themselves a few definite, basic ideas on how they can best help their husbands, and these ideas they carry out faithfully in their daily lives.

There have been amusing sidelights. Before writing this series on dental wives, the writer believed that dentistry occupied entirely too prominent a place in the family conversation. Of course, she was pleased that her husband discussed his dental problems wtih her, and she was genuinely interested in the major events of his professional career. However, there were times when she felt that simply nothing but dentistry was talked at home, and it fascinated her to watch the skill with which her dental husband could seize a conversational topic of hers and swiftly bring it right back to a discussion of some phase of dentistry.

Now all that is changed. It is she, not her husband, who introduces dentistry into the conversation. She has spent a good deal of time during the past three years thinking about dentistry, and talking with dentists and dental wives, and now the subject frankly fascinates her. And it is her husband who stirs restlessly in his chair and tries desperately to change the subject! After all, he has spent a long hard day at the office and would like to be diverted, for a few hours at least, from his profession.

This is an anniversary for *Dental Wives,* and all anniversaries are occasions. They are times for reflection, for looking back over the past, and for looking forward to the years to come. They are times for sentiment, also; and for expression of gratitude for all the good help and guidance one has received.

And so the writer tips her new fall bonnet to the many dentists and their wives who have so graciously cooperated in making these articles possible, to TIC, and to that Special Dentist who has never failed to encourage and to help every step of the way.

"WHAT I'D LIKE TO DO IS TUNE IN ON ONE OF THOSE CLOSED TV CIRCUITS FOR MEDICAL MEN."

How to care for your hands

by Herman Goodman, M.D.[1]

How to care for the hands of the dentist is a question asked several times each week in the office of this writer. The answer is difficult.

First and foremost, remember, doctor, you are a person in addition to being a dentist. You, the person, like other persons, is exposed to toxic substances. You have hobbies. You have household exposures. Keep a diary and write down each substance you touch in a twenty-four hour period.

Part of the answer to how to care for the hands of the dentist requires a statement on the care of the normal skin. You need not be reminded of the absolute need for proper soap and water washing of the hands, manicure, and avoidance of exposure to over-hot or over-cold things. You know you must not neglect minor cuts. You must manage to restrain yourself from biting the nails or pulling at the free edges. Recall barriers to toxic materials. Twenty years ago this writer was faced with the problem of how to protect the hands of professional and trade people who are required to expose the skin of their hands to noxious or toxic materials. The writer wrote formulas and prepared chemical and physical barriers. The principle was to simulate the acid cloak of the normal non-hairy skin of the palms, and to provide an invisible glove. The material available was bentonite. The vehicle was a non-alkali creme. (2)

More recently chemists provided one of the most remarkable synthetic materials ever. It is silicone. You know about silicone. It is an ingredient of a patented tooth preparation and is the vehicle for aureomycin for root canal work. The silicones are ideal for protection of the hands of the dentist. The silicones available for this purpose are silicone oil and alcohol miscible silicone. Four manufacturers (3) supply products for application to the hands. Each manufacturer utilizes the silicone oil in its own manner. Bentonite, petrolatum, plasticized creme, and acid mantle cream silicones are on the market. One additional manufacturer (4) prepares a liquid-alcohol miscible silicone in specially denatured ethanol.

Try each of the five and determine for yourself which is most desirable for you. Or you can have your pharmacist prepare a modification of one of these offered or you can try one of the writer's formulas. (5)

Please remember that the silicones are not offered as curative! They are to be regarded as protective. They protect the skin of your hands by reason of their water repellency, complete inertness, and property of adherence.

Today dermatologists report increasing numbers of dentists sorely affected in their professional and non-professional environment by the host of old and new materials. Materials handled with apparent impunity for years, if not decades, act as noxious or toxic materials. The skin of the hands is intolerant of them. You can chart the possibilities of cause of the skin irritation: Exposure to professional materials; exposure to non-professional (household and hobby) materials; combinations of first and second and mystery disease of the skin and hands.

Exposure to professional materials as the cause of irritation of the skin of the hands is determined by taking a partial vacation from the profession. Restoration to health of the skin of the hands when away from professional work means something within the area of activity of your profession lies at the bottom of your skin trouble. Then you and your dermatologist friends become detectives and seek and find the specific cause of your trouble.

Vacation from the office and its professional tasks may not lead to freedom of skin irritation. Then the thing to do is take a complete vacation from your household and hobbies. You desert your favorite shaving cream, after-shave lotion, and the many other items you would otherwise touch in daily living. Hands improve when restricted to items of your professional life. Your dermatologist friends turn their attention to the objects in your home environment. They seek and, let us hope, ultimately find the cause of your trouble, eliminate it, and you are cured!

It is possible the irritation of the skin may be due to, or continued by, a combination of materials —those of the office and the home.

The fourth possibility is a sad one. The unfortunate skin trouble persists despite long vacations from work and from normal non-office activity. The dentists wear gloves all the time. They have tried everything—going to Florida, living on a desert.

The only diagnosis possible is a mystery disease of the skin of the hands.

That about covers the subject. Finally, please remember your doctor degree is in dental and oral surgery. You never became a dermatologist. You

(*Continued on page sixteen*)

Rx FOR LIVING

Dentist George Albert Selleck — Gourmet Chef

by Joseph George Strack

A three-part series — Part II

Chef and dental educator, Doctor Selleck uses telling analogies from either profession, sometimes combines them to form unique observations:

"A recipe means nothing. It only indicates what goes into a dish. You must know much more — kitchen mechanics, how to put things together, how to stack pieces of chicken after they have been cooked, how to keep such food warm. It's like this: in teaching, I give ten students the precise measurements of a tooth, a lower molar, let us say, and request them to carve a model of such a tooth. From them I get ten different molars. That is the way it is with a recipe."

Why? Because cooking is an art as well as a science. Like all art, it requires imagination, creative ability, a flair for visualizing the end product—and the willingness to work painstakingly and without regard to the time and effort required. Food plays such an important part in our lives, affecting as it does our growth, figure, well-being, and happiness, Doctor Selleck wonders why so relatively few people take an intelligent interest in it.

"Eating can be a chore—even an ulcer-causing, time-consuming evil, as it is for the hurry-and-worry group—or it can be one of the most luxurious, health-building pleasures in all human experience," he says. "It has been said that most of us do not use more than ten per cent of our mental ability. I don't know how accurate that statement is, but I am quite sure that we Americans do not use even that percentage of our taste potential. Our taste buds, our palates, our stomachs—these organs for health and happiness remain undeveloped, as it were, for the whole lifetime of many men and women. Generation after generation passes on its eating habits and cooking prejudices, and most of us become, by such culinary heritage, the unimaginative disciples of immature, undeveloped, almost primitive philosophies of cooking."

"If we are to experience the magnificent, limitless variety of taste pleasures human nature is heir to, we must break away from mundane, uninteresting foods, unimaginatively prepared, and the eating habits, injurious to health, that too many of us have blindly accepted without analysis or thought of any kind. Once we examine the cast-iron format of our eating and cooking habits for what it is, and decide to experiment with new foods and new ways of preparing foods, we shall find a new world of zestful living that we never knew could exist. And we shall learn also that we don't have to be great

Doctor Selleck and friends looking over one of the many feature articles written about him.

Covers for Selleck Menus

chefs or buy expensive, exotic foods to enjoy the sound, discriminating tastes of the gourmet. Good eating is not necessarily the luxurious monopoly of the rich or the *bons vivants.*"

A favorite opinion of his, one that always shocks his listeners who hear it for the first time, is his solemn, startling observation: "We should eat more 'garbage.'" He quickly explains, with a grin: "We are extravagant and wasteful—the most extravagant and wasteful people in the world. Why? Well, primarily because we have so much here. This is the one nation in the world that has more food, year in and year out, than it needs. France and Italy *combined* have less area than the State of California, yet each country has four times as great a population as California. Result: the French and the Italians, with no food resources to spare—with hardly enough food to go around, in fact—have learned how to cook and eat whatever they can get. Necessity has become more and more the mother of invention in this instance, for the ingenuity of the French and the Italians have made them outstanding culinary artists, the world's greatest chefs, in the opinion of many people. They make superb delicacies from rabbit, frog legs, snails. They do wonderful things with what we consider 'garbage' —the outer leaves of lettuce and spinach, beet tops, and chard; the brains, tongue, sweetbreads, kidneys. No epicure could go without such foods, properly prepared. Yet most of us throw away these potentials of a truly excellent lunch or dinner."

How to Eat

"Dining is an art. It's an adventure. It's fun. It calls for a healthy appetite, proper environment, a relaxed state of mind, good companions, and, of course, well-cooked, flavorful, nutritious food." George Selleck returned to his favorite theme—the philosophy of the epicure. "If one does not enjoy eating, there must be something wrong with the food or with the diner. It is natural to enjoy the art of good eating. In other words, food is fun, don't come to the dining table with a calorie chart, a timetable, office worries, fatigue, tensions, or a quarrelsome nature. Instead, eat, drink, and be merry."

George Selleck became interested in cooking during his late teens, while at college. He discovered that he could eat cheaper and better by preparing his own meals and snacks, rather than patronizing restaurants and diners. Indeed, there were days when he did not have the cash to dine at a restaurant and he had to use his ingenuity to assemble the "makings" of a home-made meal.

Some of his fellow students liked the idea of sharing his meals with him, and soon young Selleck learned one of the greatest pleasures of life—the combination of good eating and good companionship.

By the time he obtained his coveted D.D.S., he had started on the long road to mastery of food preparation. That was almost forty years ago, but he says, "Such a period of time is not too much for the training of a first-rate chef. It is, let us admit,

WITCHING NUMBER

Once a year you can depend
Juniors in every house will spend
A lot of precious time on teeth!
(Do not expect to see a wreath
Of toothpaste circling the gums,
Or dental floss removing crumbs.
Have no faith they'll gargle to
Flush out cookies' residue,
Or choose the apple as ideal
Finish to a sugary meal!)
These teeth they tend with such good grace
Belong to jack-o-lantern's face!
Yes, they will neatly clean and trim
Biscuspids that belong to him—
Which leads this dentist to reflect
No doubt the young ones would protect
Their own teeth with an interest more
Intense if they had only four!

Helen Harrington

substantial preparation, but not necessarily excessive." Doctor Selleck's "substantial preparation" includes the preparation of thousands of unusual, imaginative meals during those years — luncheons, dinners, and barbecues, with as many as 150 guests for a single meal! He acts as *Le Chef de Cuisine* and Doctor George Delagnes, another distinguished gourmet, wine expert, and close friend, serves as *Le Sommelier* at the annual al fresco dinner of the San Francisco Alumni Chapter of Xi Psi Phi.

Next Month — Part III, Conclusion

Some Gourmet Recipes

Garden Torta

3 pounds of spinach
1 cup of water
4 medium-sized zucchini squash
¼ cup of olive oil
3 tablespoons of Parmesan (grated)
4 eggs
2 slices of bread (remove the crust)
¼ cup of sweet cream
salt to taste
⅛ teaspoon of pepper
a pinch of powdered thyme
¼ cup of chopped parsley
3 green sliced onions

Wash and cull the spinach. Steam it in one cup of water for 5 minutes, and chop it finely. Slice the unpeeled squash into ¼-inch circles. Sauté these in oil, placing a cover on the pan to steam slightly. (But do not cook thoroughly.) Add the Parmesan cheese to the spinach, next the eggs (one at a time), whipping thoroughly between each egg. Then soak the bread in the cream, and whip this into the mixture, adding seasoning and parsley. Fold in the squash and the green onions — and be careful not to break the slices of squash. Turn it into a buttered 8x12x12-inch baking dish and bake in a 350-degree oven for approximately 45 minutes. Test it with a straw, as you would a cake. You will have sufficient *torta* for a dozen hungry diners.

Cheese Masterpiece

1 pound of ripe Camembert
4 ounces of Amontillado Sherry
1 pound sweet butter
3 tablespoons of dry bread crumbs

Cut the rind from the Camembert. Press the cheese into a bowl, and cover it with the sherry. Let it stand overnight in a cool place.

Cream the sweet butter in a warm bowl. Drain the sherry from the cheese and reserve. With a fork, mush cheese; then add the butter and cream thoroughly. Blend in the sherry, and put the bowl in the refrigerator until the cheese sets. Then place the bowl in warm water, up to its rim, for one minute. (This will cause it to unmold so that it can be put on a serving plate.) Garnish it with the dry bread crumbs. You will have approximately two cups of the Cheese Masterpiece.

Grilled Chicken Marinade

1 cup of olive oil
½ cup of orange juice
juice of ½ lemon
2 green onions (chopped fine)
1 ounce of chopped parsley
1 teaspoon of chopped marjoram, thyme, and basil—mixed. (Get these fresh, if you can.)
1 tablespoon of grated lemon peel
¼ teaspoon of ground black pepper

Mix the orange and lemon juices by using a wire whip. Then add the other ingredients, one at a time, whipping them in to blend them carefully.

Place pieces of the cut chicken in the marinade in a plastic bag. Tie the end of the bag and place it in a cold place, but not in the refrigerator, overnight.

When you are ready for the barbecuing, remove the chicken pieces from the marinade, and save the marinade. You can use the marinade to baste the chicken while it is on the grill.

Salt and pepper the chicken while barbecuing.

Clams a la Selleck

Reduce a gill (approximately a ½ pint) of whipping cream to custard consistency by placing it in a small open pan on an asbestos pad over a low flame. Break the bubble that repeatedly forms on top of the cream, until the volume of the cream is reduced to one-third.

Cream 1 cube of butter. Mix in 1 tablespoon of chopped parsley and ½ tablespoon of chopped garlic. Mix together with the reduced cream.

Open Puget Sound cockle clams over a bowl (to keep the juice). Place each clam on its half-shell on a bed of rock salt so that it retains the heat and stays upright. Spoon the sauce over each clam and place them in a 350 degree oven for approximately 15 minutes.

CARE OF HANDS

(Continued from page twelve)

cannot distinguish or diagnose the 14,000 named skin diseases! When, if and as the skin of your hands acts as if abnormal, see your friend the skin specialist. Remember: a patient who treats himself has a fool for a doctor!

1Author of *Cosmetic Dermatology; Treatment of Common Skin Diseases; Dermatologic Formulary and Cosmetic Recipe Book; Notable Contributors to the Knowledge of Dermatology*, etc.

2Hydrogen ion concentration of the skin, *Urol. & Cutan. Rev.*, 47:470, Aug. 1943

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Nature and Uses of Bentonite, *Am. Pharm. Assn.*, 9:249, Sept. 1944

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Use of Silicone Compound Fluid in Hand Dermatitis, *N. Y. State Pharmacist*, 28:30, Nov. 1953.

3"Silicote," Arnar-Stone Laboratories, Evanston, Ill.; "Covicone," Abbott Laboratories, North Chicago, Ill.; "Proderna," Westwood Pharmaceuticals, Buffalo, N.Y.; "Domicone," Dome Chemical Company, New York, N.Y.; silicone compound fluids, Dow Corning, New York, N.Y.; G.E. Silicone Division, Waterford, N.Y.; Linde Air Products, N.Y., N.Y.

4"On Hand," Lentheric, New York, N.Y.

5Pomade of Acid Silicone Oil (Goodman)

Silicone oil, 350 centistokes	20.
Corn oil	24.
Sodium lauryl sulfate	2.
Cetyl alcohol	4.
Stearyl alcohol	18.
Citric acid	1.
Water to dissolve the citric acid	
Mineral oil (55 viscosity)	26.
Glyceryl monostearate (acid compatible)	5.

Suggested mode of preparation: Melt the solids at moderate heat, warm the oils; dissolve the citric acid in warmed water and mix all by mechanical agitation.

Application of Silicones in Acidified Isopropanol (Goodman)

Alcohol miscible silicone	5.-10.
Silicone oil, 20 centistokes	5.-10.
Citric acid	1.
Isopropanol, 99% to make	100.

Cherry Blossom Dentistry

(Continued from page four)

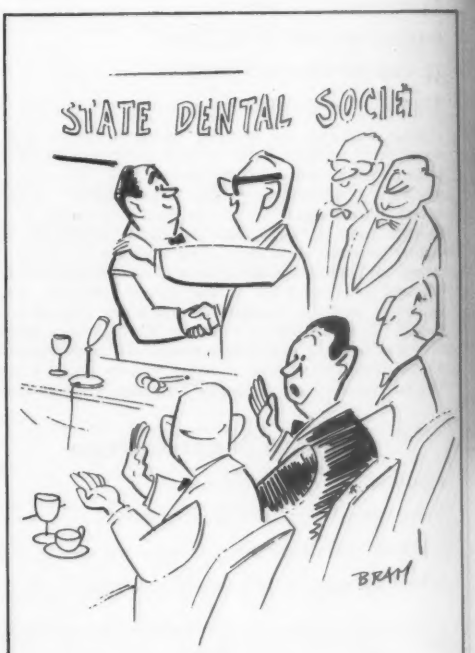
The writer's tour ended in a large conference room adjacent to the dean's office. Here tea was served and a group of professors discussed, through an interpreter, the problems of their school. They were an enthusiastic group and soon asked many questions about American dental schools.

One of their biggest problems is the lack of American-trained professors. Before the war, most of the professors attended American dental schools, but the war brought an end to this practice. Their faculty now is composed of young doctors who received their training right there in Osaka Dental College. This has proved stagnating to the different departments, and they feel the need of an influx of new and better American techniques.

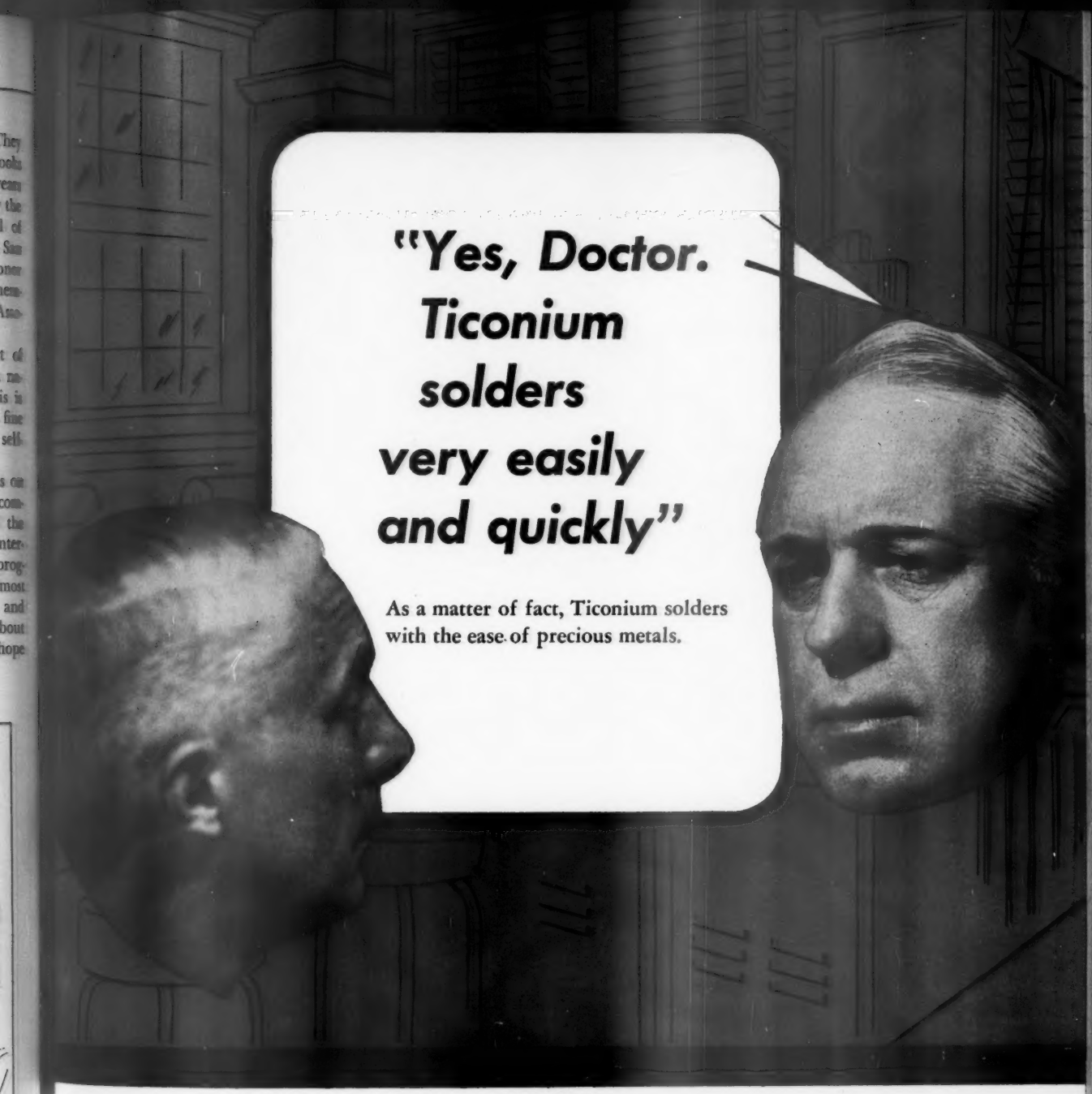
Another problem to them is the lack of foreign dental publications, both books and periodicals. Because of Japan's postwar relations with other countries and her financial restrictions, they have been unable to obtain many publications. They were extremely grateful for a donation of books and periodicals made by Northwestern several years ago and for donations made to them recently by the American Dental Association and the School of Dentistry, College of Physicians and Surgeons, San Francisco. Incidentally, occupying a place of honor in the conference room was a certificate commemorating the visit of the first American Dental Association mission to Japan in July 1951.

One shudders at the thought of the effect of war on professional education, especially on a nation as defeated as Japan has been. But this is counteracted by a feeling of admiration for a fine group of dental leaders who are working so selflessly under difficult conditions.

It is good to know that Japanese dentistry is on a footing capable of steady advancement, if accompanied by the ceaseless and united efforts of the profession there. With better equipment and enterprising faculties like the one at Osaka, their progress could be unlimited. It has already been almost miraculous in view of the physical damage and the social and economic dislocation brought about by the war. Their leading men are filled with hope for the future.



"WE SHOULD HAVE A PERMANENT PRESIDENT. IT'S SINFUL TO RUIN A GOOD PRACTICE EVERY YEAR WITH SOCIETY ADMINISTRATION DUTIES."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The creation of Japan has been attributed to the sun goddess. Since the close of World War II, however, the land of the rising sun has become a more democratic country and the mythology of

JAPAN

the past is slowly giving way to the mechanics of a modern world. The handwritten Japanese characters on our cover can be translated to read: "Dentistry in Japan." Through the ceaseless efforts of the professional people of Japan, their dentistry is on a sound footing with the educational emphasis shifting from restoration to prevention.

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